



Group Health Cooperative

2016 Benefits Booklet

Important Notice Under Federal Health Care Reform

Group Health recommends each Enrollee choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Enrollee's health care. The Enrollee has the right to designate any Network Personal Physician who participates in one of the Group Health networks and who is available to accept the Enrollee or the Enrollee's family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

For children, the Enrollee may designate a pediatrician as the primary care provider.

The Enrollee does not need Preauthorization from Group Health or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the Group Health network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Preauthorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Women's health and cancer rights

If the Enrollee is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Enrollee will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services will be provided in consultation with the Enrollee and the attending physician and will be subject to the same Cost Shares otherwise applicable under the Benefits Booklet.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Carriers offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For More Information

Group Health will provide the information regarding the types of plans offered by Group Health to Enrollees on request. Please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

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I. Introduction

This Benefits Booklet is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between Group Health Cooperative (“Group Health”) and the Group. The benefits were approved by the Group who contracts with Group Health for health care coverage. This Benefits Booklet is not the Group medical coverage agreement itself. In the event of a conflict between the Group medical coverage agreement and the benefits booklet, the benefits booklet language will govern.

The provisions of the Benefits Booklet must be considered together to fully understand the benefits available under the Benefits Booklet. Words with special meaning are capitalized and are defined in Section XII.

Contact Group Health Customer Service at 206-901-4636 or toll-free 1-888-901-4636 for benefits questions.

II. How Covered Services Work

A. Accessing Care.

1. Enrollees are entitled to Covered Services from the following:

Enrollees are entitled to Covered Services only at Network Facilities and from Network Providers, except for Emergency services and care pursuant to a Preauthorization.

A listing of Network Personal Physicians, specialists, women’s health care providers and Group Health-designated Specialists is available by contacting Customer Service or accessing the Group Health website at www.ghc.org.

2. Primary Care Provider Services.

Group Health recommends that Enrollees select a Network Personal Physician when enrolling. One personal physician may be selected for an entire family, or a different personal physician may be selected for each family member. For information on how to select or change Network Personal Physicians, and for a list of participating personal physicians, call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington at 1-888-901-4636 or by accessing the Group Health website at www.ghc.org. The change will be made within 24 hours of the receipt of the request if the selected physician’s caseload permits. If a personal physician accepting new Enrollees is not available in your area, contact the Group Health Customer Service Center, who will ensure you have access to a personal physician by contacting a physician’s office to request they accept new Enrollees.

In the case that the Enrollee’s personal physician no longer participates in Group Health’s network, the Enrollee will be provided access to the personal physician for up to 60 days following a written notice offering the Enrollee a selection of new personal physicians from which to choose.

3. Specialty Care Provider Services.

Unless otherwise indicated in Section II. or Section IV., Preauthorization is required for specialty care and specialists that are not Group Health-designated Specialists and are not providing care at facilities owned and operated by Group Health.

Specialty Care Provider Copayment.

The following providers are subject to the specialty Copayment level: allergy and immunology, anesthesiology, audiology, cardiology (pediatric and cardiovascular disease), critical care medicine, dentistry, dermatology, endocrinology, enterostomal therapy, gastroenterology, genetics, hepatology, infectious disease, massage therapy, neonatal-perinatal medicine, nephrology, neurology, nutrition, hematology/oncology, occupational medicine, occupational therapy, ophthalmology, orthopedics, ENT/otolaryngology, pathology, physiatry (physical medicine), physical therapy, podiatry, pulmonary medicine/disease, radiology (nuclear medicine, radiation therapy), respiratory therapy, rheumatology, speech therapy, sports medicine, general surgery and urology.

Group Health-designated Specialist.

Enrollees may make appointments with Group Health-designated Specialists at facilities owned and operated by Group Health without Preauthorization. To access a Group Health-designated Specialist, consult your Group Health personal physician, contact Customer Service for a list of Group-Health-designated Specialists, or view the Provider Directory located at www.ghc.org. The following specialty care areas are available from Group Health-designated Specialists: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy, smoking cessation, speech/language and learning services and urology.

4. Hospital Services.

Non-Emergency inpatient hospital services require Preauthorization. Refer to Section IV. for more information about hospital services.

5. Emergency Services.

Emergency services at a Network Facility or non-Network Facility are covered. Enrollees must notify Group Health by way of the Group Health Hospital notification line (1-888-457-9516 as noted on your member identification card) within 24 hours of any admission, or as soon thereafter as medically possible. Coverage for Emergency services at a non-Network Facility is limited to the Allowed Amount. Refer to Section IV. for more information about Emergency services.

6. Urgent Care.

Inside the Group Health Service Area, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Outside the Group Health Service Area, urgent care is covered at any medical facility. Refer to Section IV. for more information about urgent care.

7. Women's Health Care Direct Access Providers.

Female Enrollees may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is contracted by Group Health to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Enrollee's Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Enrollee's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Enrollee or her chosen provider must obtain Preauthorization in accordance with applicable Group Health requirements.

8. Process for Medical Necessity Determination.

Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Enrollees will be notified in writing when a determination has been made.

First Level Review:

First level reviews are performed or overseen by appropriate clinical staff using Group Health approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the Enrollee's medical record, and consultation with the attending/referring physician and multidisciplinary health care team. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The Enrollee or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the requesting physician when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the

requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

Second Level (Practitioner) Review:

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the requesting physician when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

B. Administration of the Benefits Booklet.

Group Health may adopt reasonable policies and procedures to administer the Benefits Booklet. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

C. Confidentiality.

Group Health is required by federal and state law to maintain the privacy of Enrollee personal and health information. Group Health is required to provide notice of how Group Health may use and disclose personal and health information held by Group Health. The Notice of Privacy Practices is distributed to Enrollees and is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.

D. Modification of the Benefits Booklet.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of the Benefits Booklet, convey or void any coverage, increase or reduce any benefits under the Benefits Booklet or be used in the prosecution or defense of a claim under the Benefits Booklet.

E. Nondiscrimination.

Group Health does not discriminate on the basis of physical or mental disabilities in its employment practices and services. Group Health will not refuse to enroll or terminate a Enrollee's coverage on the basis of age, sex, race, religion, occupation or health status.

F. Preauthorization.

Covered Services may require Preauthorization. Refer to Section IV. for more information. Group Health recommends that the provider requests Preauthorization. Enrollees may also contact Customer Service. Preauthorization requests are reviewed and approved based on Medical Necessity, eligibility and benefits.

G. Recommended Treatment.

Group Health's medical director will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment will be made in good faith. Enrollees have the right to appeal coverage decisions (see Section VIII.). Enrollees have the right to participate in decisions regarding their health care. An Enrollee may refuse any recommended services to the extent permitted by law. Enrollees who obtain care not recommended by Group Health's medical director do so with the full understanding that Group Health has no obligation for the cost, or liability for the outcome, of such care.

H. Second Opinions.

The Enrollee may access a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Enrollee may request Preauthorization or may visit a Group Health-designated Specialist for a second opinion. When requested or indicated, second opinions are provided by Network Providers and are covered with Preauthorization, or when obtained from a Group Health-designated Specialist. Coverage is determined by the

Enrollee's Benefits Booklet; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered. Preauthorization for a second opinion does not imply that Group Health will authorize the Enrollee to return to the physician providing the second opinion for any additional treatment. Services, drugs and devices prescribed or recommended as a result of the consultation are not covered unless included as covered under the Benefits Booklet.

I. Unusual Circumstances.

In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, Group Health will not be liable for administering coverage beyond the limitations of available personnel and facilities.

In the event of unusual circumstances such as those described above, Group Health will make a good faith effort to arrange for Covered Services through available Network Facilities and personnel. Group Health shall have no other liability or obligation if Covered Services are delayed or unavailable due to unusual circumstances.

J. Utilization Management.

All benefits are limited to Covered Services that are Medically Necessary and set forth in the Benefits Booklet. Group Health may review a Enrollee's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, Group Health may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria.

Group Health will not deny coverage retroactively for services with Preauthorization and which have already been provided to the Enrollee except in the case of an intentional misrepresentation of a material fact by the patient, Enrollee, or provider of services, or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application, or for nonpayment of premiums.

III. Financial Responsibilities

A. Premium.

The Subscriber is liable for payment to the Group of his/her contribution toward the monthly premium, if any.

B. Financial Responsibilities for Covered Services.

The Subscriber is liable for payment of the following Cost Shares for Covered Services provided to the Subscriber and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the Subscriber during each year until the annual Deductible is met. Covered Services must be received from a Network Provider at a Network Facility, unless the Enrollee has received Preauthorization or has received Emergency services.

There is an individual annual Deductible amount for each Enrollee and a maximum annual Deductible amount for each Family Unit. Once the annual Deductible amount is reached for a Family Unit in a calendar year, the individual annual Deductibles are also deemed reached for each Enrollee during that same calendar year.

2. Plan Coinsurance.

After the applicable annual Deductible is satisfied, Enrollees may be required to pay Plan Coinsurance for Covered Services.

3. Copayments.

Enrollees shall be required to pay applicable Copayments at the time of service. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service or if other Cost Shares apply.

4. Out-of-pocket Limit.

Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV. Total Out-of-pocket Expenses incurred during the same calendar year shall not exceed the Out-of-pocket Limit.

C. Financial Responsibilities for Non-Covered Services.

The cost of non-Covered Services and supplies is the responsibility of the Enrollee. The Subscriber is liable for payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Dependents at the time of service. Payment of an amount billed must be received within 30 days of the billing date.

IV. Benefits Details

Benefits are subject to all provisions of the Benefits Booklet. Enrollees are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by Group Health's medical director and as described herein. All Covered Services are subject to case management and utilization management at the discretion of Group Health. "Case management" means a care management plan developed for a Enrollee whose diagnosis requires timely coordination.

Annual Deductible	<p>Annual Deductible without Wellness incentive: Enrollee pays \$350 per Enrollee per calendar year or \$1,050 per Family Unit per calendar year; or</p> <p>Annual Deductible with Wellness incentive: Subscriber Enrollee pays \$225 per calendar year; dependent Enrollees pay \$350 per calendar year or \$925 per Family Unit per calendar year</p>
Coinsurance	Plan Coinsurance: Enrollee pays nothing
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	<p>Limited to a maximum of \$2,000 per Enrollee or \$4,000 per Family Unit per calendar year</p> <p>The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services</p> <p>The following expenses do not apply to the Out-of-pocket Limit: Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services</p>
Pre-existing Condition Waiting Period	No pre-existing condition waiting period

Acupuncture	
Acupuncture needle treatment, limited to 8 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization.	After Deductible, Enrollee pays \$20 primary care provider services Copayment
No visit limit for treatment for Chemical Dependency.	
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Allergy serum and injections.	After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment

Ambulance	
Emergency ground or air transport to any facility.	Enrollee pays 20% coinsurance
Non-Emergency ground or air interfacility transfer to or from a Network Facility when initiated by Group Health.	Enrollee pays 20% coinsurance Hospital-to-hospital ground transfers: No charge; Enrollee pays nothing

Cancer Screening and Diagnostic Services	
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org , or upon request from Customer Service. See Preventive Services for additional information.	No charge; Enrollee pays nothing
Diagnostic laboratory and diagnostic services for cancer. See Diagnostic Laboratory and Radiology Services for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Enrollee pays nothing

Chemical Dependency	
<p>Chemical dependency services including treatment provided in an outpatient or home health setting, and inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V.</p> <p>Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted. For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on an Enrollee's emotional, social, medical and/or occupational functioning.</p> <p>Chemical dependency services must be provided at a Group Health-approved treatment facility or treatment program.</p> <p>Chemical dependency services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a chemical dependency treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.</p> <p>Court-ordered chemical dependency treatment shall be covered only if determined to be Medically Necessary.</p> <p>Residential Treatment and non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Acute chemical withdrawal (detoxification) services for alcoholism and drug abuse. "Acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a Enrollee for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Enrollee's health.</p> <p>Coverage for acute chemical withdrawal (detoxification) is provided without Preauthorization. Enrollees must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.</p>	<p>Emergency Services Network Facility: After Deductible, Enrollee pays \$300 Copayment</p> <p>Emergency Services Non-Network Facility: After Deductible, Enrollee pays \$300 Copayment</p> <p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p>

Group Health reserves the right to require transfer of the Enrollee to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Enrollee refuses transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Enrollee.	
Exclusions: Experimental or investigational therapies, such as wilderness therapy; facilities and treatment programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State	

Circumcision	
<p>Circumcision.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

Clinical Trials	
<p>Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal and state law.</p> <p>Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.</p> <p>Clinical trials require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis	

Dental Services and Dental Anesthesia	
<p>Dental services including accidental injury to natural teeth.</p> <p>Dental Services necessitated by accidental injury to sound natural teeth.</p>	<p>Accidental injury: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

Evaluation and a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the treatment plan time frames.	Other dental services: Not covered, Enrollee pays 100% of all charges
General anesthesia services and related facility charges for dental procedures for Enrollees who are under 7 years of age, or are physically or developmentally disabled or have a Medical Condition where the Enrollee's health would be put at risk if the dental procedure were performed in a dentist's office. General anesthesia services for dental procedures require Preauthorization.	Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment
Exclusions: Injuries caused by biting or chewing; malocclusion as a result from an accidental injury; reconstructive surgery to the jaw in preparation for dental implants, dental implants, orthodontia; treatment not completed within the written treatment plan time frame, unless treatment is delayed due to a medical condition and the treatment plan is modified; any other dental service not specifically listed as covered	

Devices, Equipment and Supplies (for home use)	
<ul style="list-style-type: none"> • Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Enrollee's home. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and oxygen equipment, and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. Group Health will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms, limited to 2 every 6 months. Replacements within this 6 month period are covered when Medically Necessary due to a change in the Enrollee's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Wigs or hairpieces for hair loss due to radiation or chemotherapy. • Breast pumps and one supply kit are covered for 6 months per pregnancy in full under Preventive Services. <p>When provided in lieu of hospitalization, benefits will be the</p>	<p>Enrollee pays 20% coinsurance</p> <p>Covered wigs or hairpieces limited to \$100 lifetime maximum</p>

<p>greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting.</p> <p>Devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment require Preauthorization.</p>	
<p>Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis (except as noted above); take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Enrollee's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Enrollee's home or personal vehicle</p>	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	Enrollee pays 20% coinsurance
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	<p>Value based medications as determined by Group Health: Enrollee pays \$5 Copayment</p> <p>Preferred generic drugs (Tier 1): Enrollee pays \$20 Copayment</p> <p>Preferred Brand name drugs (Tier 2): Enrollee pays \$40 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): Enrollee pays 50% coinsurance (up to \$250 maximum Copayment)</p>
Diabetic retinal screening.	No charge; Enrollee pays nothing

Dialysis (Home and Outpatient)	
<p>Dialysis in an outpatient or home setting is covered for Enrollees with end-stage renal disease (ESRD).</p> <p>Dialysis is covered when the Enrollee is temporarily absent from the Service Area for up to 21 days.</p>	<p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

Dialysis requires Preauthorization. Dialysis to be provided outside of the Service Area must be preauthorized prior to the Enrollee traveling outside the Service Area.	
Injections administered by a professional in a clinical setting during dialysis.	Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	<p>Value based medications as determined by Group Health: Enrollee pays \$5 Copayment</p> <p>Preferred generic drugs (Tier 1): Enrollee pays \$20 Copayment</p> <p>Preferred Brand name drugs (Tier 2): Enrollee pays \$40 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): Enrollee pays 50% coinsurance (up to \$250 maximum Copayment)</p>

Drugs - Outpatient Prescription	
<p>Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles and blood glucose test strips), mental health drugs, self-administered injectables, and routine costs for prescription medications provided in a clinical trial. “Routine costs” means items and services delivered to the Enrollee that are consistent with and typically covered by the plan or coverage for a Enrollee who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services.</p> <p>All drugs, supplies and devices must be obtained at a Group Health-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the Group Health Service Area. Information regarding Group Health-designated pharmacies is reflected in the Group Health Provider Directory, or can be obtained by contacting the Group Health Customer Service Center.</p> <p>Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services.</p> <p>Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.ghc.org.</p>	<p>Value based medications as determined by Group Health: Enrollee pays \$5 Copayment</p> <p>Preferred generic (Tier 1): Enrollee pays \$20 Copayment</p> <p>Preferred Brand name drugs (Tier 2): Enrollee pays \$40 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): Enrollee pays 50% coinsurance (up to \$250 maximum Copayment)</p>
Injections administered by a professional in a clinical setting.	After Deductible, Enrollee pays \$20 primary care

	provider services Copayment or \$40 specialty care provider services Copayment
Growth hormones.	After Deductible, \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Over-the-counter drugs not included under Preventive Care.	Not covered; Enrollee pays 100% of all charges
Mail order drugs dispensed through the Group Health-designated mail order service.	<p>Enrollee pays the prescription drug Cost Share for each 90 day supply or less</p> <p>Value based medications as determined by Group Health: Enrollee pays \$10 Copayment</p> <p>Preferred generic drugs (Tier 1): Enrollee pays \$40 Copayment</p> <p>Preferred brand name drugs (Tier 2): Enrollee pays \$80 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): Enrollee pays 50% coinsurance (up to \$750 maximum copayment)</p>
<p>The Group Health Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.ghc.org, or upon request from Customer Service.</p> <p>Enrollees may request a coverage determination by contacting Customer Service. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits.</p> <p>Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Standard reference compendia" means the American Hospital Formulary Service – Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia – Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.</p> <p>Generic drugs are dispensed whenever available. A generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Enrollee elects to purchase a brand-name drug instead of</p>	

the generic equivalent (if available), the Enrollee is responsible for paying the difference in cost in addition to the prescription drug Cost Share.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when an Enrollee tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If an Enrollee has a new prescription for a chronic condition, the Enrollee may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.

Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through Group Health's preferred specialty pharmacy vendor and/or network of specialty pharmacies. For a list of specialty drugs or more information about Group Health's specialty pharmacy network, please go to the Group Health website at www.ghc.org or contact Customer Service at 206-901-4636 or toll-free at 1-888-901-4636.

The Enrollee's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Enrollees' right to know what drugs are covered and the coverage limitations. Enrollees who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact Group Health at 206-901-4636 or toll-free 1-888-901-4636 or by accessing the Group Health website at www.ghc.org.

Enrollees who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Benefits Booklet, may contact the Washington State Office of Insurance Commissioner at toll-free 1-800-562-6900. Enrollees who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.

Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Enrollees who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Enrollee could be subject to payment of higher Part D premiums if the Enrollee subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. An Enrollee who discontinues coverage must meet eligibility requirements in order to re-enroll.

Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	
Emergency services at a Network Facility or non-Network Facility. See Section XII. for a definition of Emergency.	Network Facility: After Deductible, Enrollee pays \$300 Copayment
Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize	Non-Network Facility: After Deductible, Enrollee pays \$300 Copayment

<p>a patient.</p> <p>Enrollees must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.</p> <p>If an Enrollee is admitted as an inpatient directly from a Network Facility emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share.</p> <p>If an Enrollee is hospitalized in a non-Network Facility, Group Health reserves the right to require transfer of the Enrollee to a Network Facility upon consultation between a Network Provider and the attending physician. If the Enrollee refuses to transfer to a Network Facility or does not notify Group Health within 24 hours following admission, all further costs incurred during the hospitalization are the responsibility of the Enrollee.</p> <p>Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.</p>	
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Hearing Examinations and Hearing Aids	
<p>Cochlear implants when in accordance with Group Health clinical criteria.</p> <p>Covered services for cochlear implants include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).</p> <p>Routine hearing exams and hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at Group Health-approved facilities.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
Hearing aids including fitting and follow-up care.	<p>Enrollee pays nothing, limited to an Allowance of \$800 maximum, including repairs, during any consecutive 36 month period</p> <p>After Allowance: Not covered; Enrollee pays 100% of all charges</p>
<p>Exclusions: Programs or treatments for hearing loss or hearing care including, but not limited to, surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Enrollee is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs</p>	

Home Health Care	
<p>Home health care when the following criteria are met:</p> <ul style="list-style-type: none"> • The Enrollee is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The Enrollee requires intermittent skilled home health care, as described below. • Group Health's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Enrollee's home. <p>Covered Services for home health care may include the following when rendered pursuant to a Group Health-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment; medical social worker and limited home health aide services.</p> <p>Home health services are covered on an intermittent basis in the Enrollee's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.</p> <p>Home health care requires Preauthorization.</p>	<p>No charge; Enrollee pays nothing</p>
<p>Exclusions: Private duty nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above</p>	

Hospice	
<p>Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to an Enrollee and any family members who are caring for the member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Enrollee and their family during the final stages of illness. In order to qualify for hospice care, the Enrollee's provider must certify that the Enrollee is terminally ill and is eligible for hospice services.</p>	<p>After Deductible, Enrollee pays nothing</p>

<p>Inpatient Hospice Services. For short-term care, inpatient hospice services are covered with Preauthorization.</p> <p>Respite care is covered to provide continuous care of the Enrollee and allow temporary relief to family members from the duties of caring for the Enrollee for a maximum of 5 consecutive days per 3 month period of hospice care.</p> <p>Other covered hospice services, when billed by a licensed hospice program, may include the following:</p> <ul style="list-style-type: none"> • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment when billed by a licensed hospice care program. <p>Hospice care requires Preauthorization.</p>	
<p>Exclusions: Private duty nursing, financial or legal counseling services; meal services; any services provided by family members</p>	

Hospital - Inpatient and Outpatient	
<p>The following inpatient medical and surgical services are covered:</p> <ul style="list-style-type: none"> • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants. • Acute chemical withdrawal (detoxification). <p>Outpatient hospital includes ambulatory surgical centers.</p> <p>Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Enrollee and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Enrollee's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization.</p> <p>Enrollees receiving the following nonscheduled services are required to notify Group Health by way of the Group Health Hospital notification line within 24 hours following any</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p>

<p>admission, or as soon thereafter as medically possible: acute chemical withdrawal (detoxification) services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained.</p> <p>Coverage for Emergency services in a non-Network Facility and subsequent transfer to a Network Facility is set forth in Emergency Services.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	
<p>Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that have not been approved by Group Health's medical director</p>	

Infertility (including sterility)	
General counseling and diagnostic services.	Not covered; Enrollee pays 100% of all charges
Specific diagnostic services, treatment and prescription drugs.	Not covered; Enrollee pays 100% of all charges
<p>Exclusions: Diagnostic testing and medical treatment of sterility and infertility regardless of origin or cause; all charges and related services for donor materials; all forms of artificial intervention for any reason including artificial insemination and in-vitro fertilization; prognostic (predictive) genetic testing for the detection of congenital and heritable disorders; surrogacy</p>	

Infusion Therapy	
<p>Medically Necessary infusion therapy includes, but is not limited to:</p> <ul style="list-style-type: none"> • Antibiotics. • Hydration. • Chemotherapy. • Pain management. 	After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Associated infused medications.	After Deductible, Enrollee pays nothing

Laboratory and Radiology	
<p>Nuclear medicine, radiology, ultrasound and laboratory services.</p> <p>Services received as part of an emergency visit are covered as Emergency Services.</p> <p>Preventive laboratory and radiology services are covered in</p>	After Deductible, Enrollee pays nothing

accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org , or upon request from Customer Service.	
CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Customer Service for any questions regarding these services.	After Deductible, Enrollee pays \$40 specialty care provider services Copayment

Manipulative Therapy	
Manipulative therapy of the spine and extremities when in accordance with Group Health clinical criteria, limited to a total of 10 visits per calendar year.	After Deductible, Enrollee pays \$20 Copayment
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Enrollee; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet Group Health clinical criteria as Medically Necessary	

Maternity and Pregnancy	
<p>Maternity care and pregnancy services, including care for complications of pregnancy, in utero treatment for the fetus and prenatal and postpartum care are covered for all female Enrollees including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth and prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by Group Health's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.</p> <p>Delivery and associated Hospital Care, including home births and birthing centers. Home births are considered outpatient services.</p> <p>Enrollees must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Enrollee's physician, in consultation with the Enrollee, will determine the Enrollee's length of inpatient stay following delivery.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Termination of pregnancy.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee</p>

	<p>pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Birthing tubs; genetic testing of non-Enrollee; fetal ultrasound in the absence of medical indications</p>	

Mental Health	
<p>Mental health services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by Group Health's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives.</p> <p>Mental health services including medical management and prescriptions are covered the same as for any other condition.</p> <p>Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required.</p> <p>Outpatient electro-convulsive therapy treatment is covered subject to the hospital-outpatient Cost Share.</p> <p>Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by Group Health's medical director. Services provided under involuntary commitment statutes are covered only at Group Health-approved facilities.</p> <p>Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency services benefit. Coverage for services incurred at non-Network Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a Network Facility. Enrollees must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.</p> <p>Mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

<p>under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.</p> <p>Inpatient mental health services must be provided at a hospital or facility that Group Health has approved specifically for the treatment of mental or nervous disorders.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	
<p>Exclusions: Academic or career counseling; personal growth or relationship enhancement; assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating not considered Medically Necessary; specialty treatment programs such as "behavior modification programs" not considered Medically Necessary; relationship counseling or phase of life problems (V code only diagnoses); custodial care</p>	

Naturopathy	
<p>Naturopathy.</p> <p>Limited to 3 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization.</p> <p>Laboratory and radiology services are covered only when obtained through a Network Facility.</p>	<p>After Deductible, Enrollee pays \$20 Copayment</p>
<p>Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure</p>	

Newborn Services	
<p>Newborn services are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother.</p> <p>Preventive services for newborns are covered under Preventive Services.</p> <p>See Section VI.A.3. for information about temporary coverage for newborns.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>During the baby's initial hospital stay while the birth mother and baby are both confined, any applicable Deductible and Copayment for the newborn are waived</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

Nutritional Counseling	
Nutritional counseling.	After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Exclusions: Nutritional supplements; weight loss programs; pre and post bariatric surgery nutritional counseling	

Nutritional Therapy	
Dietary formula for the treatment of phenylketonuria (PKU).	After Deductible, Enrollee pays nothing
Enteral therapy (elemental formulas) for malabsorption and an eosinophilic gastrointestinal associated disorder. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Enrollee pays 20% coinsurance
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Enrollee pays nothing
Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements; special diets; prepared foods/meals	

Obesity Related Surgical Services	
Bariatric surgery is covered when Group Health criteria are met. Bariatric surgery related services require Preauthorization.	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
Exclusions: Obesity treatment and treatment for morbid obesity for any reason including any medical services, drugs, supplies, regardless of co-morbidities; specialty treatment programs such as weight reduction for any reason; medications and related physician visits for medication monitoring; pre and post bariatric surgery nutritional counseling; bariatric surgery if you had bariatric surgery within the past 10 years	

On the Job Injuries or Illnesses	
On the job injuries or illnesses.	<p>Office of Worker's Compensation Programs (OWCP) or similar Federal or State agency pays through a third party settlement: Not covered; Enrollee pays 100% of all charges</p> <p>After the third party settlement maximum is paid: Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Confinement, treatment or service that results from an illness or injury arising out of or in the course of any employment for wage or profit including injuries, illnesses or conditions incurred as a result of self-employment</p>	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy.	<p>Radiation Therapy and Chemotherapy: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p> <p>Oral Chemotherapy Drugs: Value based medications as determined by Group Health: Enrollee pays \$5 Copayment Preferred generic drugs (Tier 1): Enrollee pays \$20 Copayment Preferred Brand name drugs (Tier 2): Enrollee pays \$40 Copayment Non-Preferred generic and brand name drugs (Tier 3): Enrollee pays 50% up to \$250 Copayment limit per prescription or refill</p>

Optical (vision)	
<p>Routine eye examinations and refractions, limited to once every 12 months.</p> <p>Eye and contact lens examinations for eye pathology and to</p>	<p>Routine Exams: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

<ul style="list-style-type: none"> Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations <p>Contact lenses for eye pathology when Medically Necessary.</p> <p>One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Enrollee has been continuously covered by Group Health since such surgery. In the event an Enrollee's age or medical condition prevents the Enrollee from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Enrollee's prescription. Replacement for loss or breakage is subject to the frames and lenses benefit.</p>	<p>Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures</p>	

Oral Surgery	
<p>Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.</p> <p>Group Health's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services.</p> <p>Oral surgery requires Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature</p>	

Outpatient Services	
<p>Covered outpatient medical and surgical services in a provider's office, including chronic disease management. See Preventive Services for additional information related to chronic disease management.</p> <p>See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.</p>	<p>After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>

Plastic and Reconstructive Surgery	
<p>Plastic and reconstructive services:</p> <ul style="list-style-type: none"> • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Enrollee's appearance, when in the opinion of Group Health's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Enrollees are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered. <p>Plastic and reconstructive surgery requires Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services</p>	

Podiatry	
<p>Medically Necessary foot care.</p> <p>Routine foot care covered when such care is directly related to the treatment of diabetes and, when approved by Group Health's medical director, other clinical conditions that affect sensation and circulation to the feet.</p>	<p>After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: All other routine foot care</p>	

Preventive Services	
<p>Preventive services in accordance with the well care schedule established by Group Health. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.</p> <p>Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF).</p> <p>Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians.</p> <p>Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's</p>	<p>No charge; Enrollee pays nothing</p>

<p>preventive and wellness services guidelines.</p> <p>Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices.</p> <p>Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; female sterilization; FDA-approved contraceptive drugs, devices, including device removal, and counseling; preferred over-the-counter contraceptives and drugs as recommended by the USPSTF when obtained with a prescription; pap smears; routine mammography screening; routine prostate screening; and colorectal cancer screening for Enrollees who are age 50 or older or who are under age 50 and at high risk.</p> <p>Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support.</p> <p>Services provided during a preventive services visit, including laboratory services, which are not in accordance with the Group Health well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.</p>	
<p>Exclusions: Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel or insurance purposes that are not deemed Medically Necessary by Group Health for early detection of disease; all other diagnostic services not otherwise stated above</p>	

<p>Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy</p>	
<p>Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage therapy and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, massage therapist or speech therapist.</p> <p>Habilitative care, including: occupational therapy, physical therapy, speech therapy is covered when prescribed by a</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 Copayment</p>

<p>physician.</p> <p>Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation and Habilitative care services.</p> <p>Neurodevelopmental therapy for children age 6 and younger to restore or improve function including maintenance in cases where significant deterioration in the Enrollee's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year.</p> <p>Non-Emergency inpatient hospital services and massage therapy require Preauthorization.</p>	
<p>Exclusions: Specialty treatment programs; inpatient Residential Treatment services; specialty rehabilitation programs including "behavior modification programs"; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Enrollee's level of functioning (except as described for neurodevelopmental therapy); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs</p>	

Sexual Dysfunction	
Sexual dysfunction diagnosis and medical treatment services.	After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Penile prosthesis, when impotence is caused by a covered medical condition, as a direct result of a covered surgery, or a result of an injury to the genitalia or spinal cord, and when other accepted treatment has been unsuccessful.	Enrollee pays 20% coinsurance
<p>Exclusions: Prescription drugs for treatment of sexual dysfunction; devices, equipment and supplies for the treatment of sexual dysfunction; penile prosthesis when impotence is caused by a psychological condition; All other devices, equipment and supplies for the treatment of sexual dysfunction not specifically listed as covered</p>	

Skilled Nursing Facility	
<p>Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 150 days per calendar year.</p> <p>Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term restorative occupational therapy, physical therapy and speech therapy.</p> <p>Skilled nursing care in a skilled nursing facility requires</p>	<p>After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p>

Preauthorization.	
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care	

Sterilization	
Female sterilization procedures. See Preventive Services for additional information.	Hospital - Inpatient: No charge; Enrollee pays nothing
Non-Emergency inpatient hospital services require Preauthorization.	Hospital - Outpatient: No charge; Enrollee pays nothing Outpatient Services: No charge; Enrollee pays nothing
Vasectomy.	Hospital - Inpatient: After Deductible, pays \$200 Copayment per day up to \$1,000 per admission
Non-Emergency inpatient hospital services require Preauthorization.	Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Exclusions: Procedures and services to reverse a sterilization	

Telehealth	
Telehealth (audio and video communication) services between a consulting distant site provider, and the originating site provider, where the Enrollee is located. The originating site is in a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.	Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment
Exclusions: Telehealth services when the originating site is not a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services; the site fee from the originating location	

Temporomandibular Joint (TMJ)	
<p>Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including:</p> <ul style="list-style-type: none"> • Orthognathic surgery for the treatment of TMJ disorders. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	After Deductible, Enrollee pays 50% coinsurance
TMJ appliances. See Devices, Equipment and Supplies for additional information.	Enrollee pays 50% coinsurance
<p>Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, severe obstructive sleep apnea; hospitalizations related to these exclusions</p>	

Tobacco Cessation	
Individual/group counseling and educational materials.	No charge; Enrollee pays nothing
Approved pharmacy products. See Drugs – Outpatient Prescription for additional pharmacy information.	No charge; Enrollee pays nothing

Transgender Services	
<p>Medical and surgical services for gender reassignment.</p> <p>Surgical services may include initial mastectomy/breast reduction, hysterectomy, salpingo-oophorectomy, colectomy, metoidioplasty, vaginoplasty, colovaginoplasty, orchiectomy, penectomy, clitoroplasty and labiaplasty.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services; travel</p>	

Transplants	
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell	Hospital - Inpatient: After Deductible, Enrollee pays \$200 Copayment per day up to \$1,000 per admission

<p>support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy.</p> <p>Services are limited to the following:</p> <ul style="list-style-type: none"> • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits • Rehospitalization • Maintenance medications during an inpatient stay <p>Organ Transplant Recipient: All services and supplies related to the organ transplant, including transportation to and from the Group Health Facilities (beyond the distance the Enrollee would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the Enrollee is accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.</p> <p>Organ Transplant Donor: The costs related to organ removal, as well as the cost of treating complications directly resulting from surgery, are covered, provided the organ recipient is an Enrollee under this Agreement, and provided the donor is not eligible for coverage under any other health care plan or government-funded program.</p> <p>Donor search costs for up to 15 searches only for allogeneic bone marrow transplants.</p> <p>Transplant services require Preauthorization.</p>	<p>Hospital - Outpatient: After Deductible, Enrollee pays \$200 Copayment</p> <p>Outpatient Services: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p>
<p>Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; living expenses; transportation expenses except as covered as Ambulance Services; costs for searches for non-allogeneic bone marrow donors</p>	

Urgent Care	
<p>Inside the Group Health Service Area, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office.</p> <p>Outside the Group Health Service Area, urgent care is covered at any medical facility.</p> <p>See Section XII. for a definition of Urgent Condition.</p>	<p>Network Emergency Department: After Deductible, Enrollee pays \$300 Copayment</p> <p>Network Urgent Care Center: After Deductible, Enrollee pays \$20 primary care provider services Copayment or \$40 specialty care provider services Copayment</p> <p>Network Provider's Office: After Deductible, Enrollee pays \$20 primary care provider services</p>

	Copayment or \$40 specialty care provider services Copayment Outside the Group Health Service Area: After Deductible, Enrollee pays \$300 Copayment
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V. General Exclusions

In addition to exclusions listed throughout the Benefits Booklet, the following are not covered:

1. Benefits and related services, supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the Benefits Booklet, except as required by federal or state law.
2. Follow-up services or complications related to non-Covered Services, except as required by federal or state law.
3. Services or supplies for which no charge is made, or for which a charge would not have been made if the Enrollee had no health care coverage or for which the Enrollee is not liable; services provided by a family member, or self-care.
4. Convalescent Care.
5. Services to the extent benefits are “available” to the Enrollee as defined herein under the terms of any vehicle, homeowner’s, property or other insurance policy, except for individual or group health insurance, pursuant to medical coverage, medical “no fault” coverage, personal injury protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be “available” to the Enrollee if the Enrollee receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.
6. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.
7. Services provided by government agencies, except as required by federal or state law.
8. Services covered by the national health plan of any other country.
9. Experimental or investigational services.

Group Health consults with Group Health’s medical director and then uses the criteria described below to decide if a particular service is experimental or investigational.

- a. A service is considered experimental or investigational for a Enrollee’s condition if any of the following statements apply to it at the time the service is or will be provided to the Enrollee:
 - 1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (“FDA”) and such approval has not been granted.
 - 2) The service is the subject of a current new drug or new device application on file with the FDA.
 - 3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
 - 4) The service is provided pursuant to a written protocol or other document that lists an evaluation of the service’s safety, toxicity or efficacy as among its objectives.

- 5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
 - 6) The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
 - 7) The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.
- b. The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
- 1) The Enrollee's medical records.
 - 2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
 - 3) Any consent document(s) the Enrollee or Enrollee's representative has executed or will be asked to execute, to receive the service.
 - 4) The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
 - 5) The published authoritative medical or scientific literature regarding the service, as applied to the Enrollee's illness or injury.
 - 6) Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding Group Health denial of coverage can be submitted to the Member Appeal Department, or to Group Health's medical director at P.O. Box 34593, Seattle, WA 98124-1593.

10. Hypnotherapy and all services related to hypnotherapy.
11. Directed umbilical cord blood donations.
12. Prognostic (predictive) genetic testing and related services, unless specifically provided in Section IV. Testing for non- Enrollees.
13. Autopsy and associated expenses.

VI. Eligibility, Enrollment and Termination

A. Eligibility.

1. Eligible Retirees and Surviving Dependents.

In these sections we may refer to retirees and surviving Dependents as "Subscribers" or "Enrollees." The Public Employee's Benefits Board (PEBB) Program will determine if an employee is eligible to enroll in retiree insurance coverage when it receives a completed *Retiree Coverage Election/Change* form. If the employee does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the employee of his or her right to an appeal. Information about appealing can be found in Subsection G.

The PEBB Program will determine if a Dependent is eligible to continue enrollment in insurance coverage as a surviving Dependent when it receives a completed *Retiree Coverage Election/Change* form. If the Dependent does not have substantive eligibility or does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the Dependent of his or her right to an appeal. Information about appealing a decision made by the PEBB Program can be found in Subsection G.

Retirees, surviving Dependents, and their enrolled Dependents, are required to enroll in Medicare Part A and Part B if entitled. Enrollees who are entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B. This is a condition of their enrollment. Enrollees must provide a copy of their Medicare card to the PEBB Program as proof of enrollment in Medicare. If an Enrollee is not entitled to either Medicare Part A or Part B on his or her 65th birthday, the Enrollee must provide the PEBB Program with a copy of the appropriate documentation from the Social Security Administration. The only exception to this rule is for employees who retired before July 1991.

2. Eligible Dependents.

To be enrolled in a medical plan a Dependent must be eligible and the Subscriber must follow the procedural requirements described in “Enrollment,” Subsection C. The PEBB Program verifies the eligibility of all Dependents and requires Subscribers provide documents that prove a Dependent’s eligibility.

- a. Lawful spouse.
- b. Registered domestic partner, defined to include the following:
 - 1) Effective January 1, 2010, a state-registered domestic partner; or
 - 2) A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the employee in a PEBB health plan or life insurance.
- c. Children. Children are eligible up to age 26 except as described in Subsection 9 of this section. Children are defined as the Subscriber’s:
 - 1) Children as defined in state statutes that establish the parent-child relationship.
 - 2) Biological children, where parental rights have not been terminated;
 - 3) Stepchildren The stepchild’s relationship to a Subscriber (and eligibility as a PEBB Dependent) ends on the same date the Subscriber’s legal relationship with the spouse or registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
 - 4) Legally adopted children;
 - 5) Children for whom the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
 - 6) Children of the Subscriber’s registered domestic partner;
 - 7) Children specified in a court order or divorce decree;
 - 8) Extended Dependents in the legal custody or legal guardianship of the Subscriber, the Subscriber’s spouse, or Subscriber’s registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. “Children” does not include foster children for whom support payments are made to the Subscriber through the state Department of Social and Health Services foster care program; and
 - 9) Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly Dependent upon the Subscriber for support and maintenance provided such condition occurs before age 26.
 - The Subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
 - The Subscriber must notify the PEBB Program in writing when his or her Dependent is not eligible under this section. The notification must be received by the PEBB Program no later than 60 days after the date that child age 26 or older no longer qualifies under this subsection.
 - A child with a disability or physical handicap who becomes self-supporting is not eligible as of the last day of the month in which he or she becomes capable of self-support.
 - A child with a developmental disability or physician handicap age 26 and older who becomes capable of self-support does not regain eligibility if he or she later becomes incapable of self-support.
 - The PEBB Program will verify the disability and dependency of children with disabilities periodically, but no more frequently than annually after the two-year period following the child’s 26th birthday.

- d. Parents.
 - 1) Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
 - The parent maintains continuous enrollment in a PEBB medical plan;
 - The parent qualifies under the Internal Revenue Code as a Dependent of the Subscriber;
 - The Subscriber continues enrollment in PEBB insurance coverage; and
 - The parent is not covered by any other group medical plan.
 - 2) Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the Subscriber. Parents may not enroll additional Dependents to their insurance coverage.

3. Eligible Retirees and Surviving Dependents.

In these sections we may refer to retirees and surviving Dependents as “Subscribers” or “Enrollees.” The Public Employee’s Benefits Board (PEBB) Program will determine if an employee is eligible to enroll in retiree insurance coverage when it receives a completed *Retiree Coverage Election/Change* form. If the employee does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the employee of his or her right to an appeal. Information about appealing can be found in Subsection G.

The PEBB Program will determine if a Dependent is eligible to continue enrollment in insurance coverage as a surviving Dependent when it receives a completed Retiree Coverage Election/Change form. If the Dependent does not have substantive eligibility or does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the Dependent of his or her right to an appeal. Information about appealing a decision made by the PEBB Program can be found in Subsection G.

Retirees, surviving Dependents, and their enrolled Dependents, are required to enroll in Medicare Part A and Part B if entitled. Enrollees who are entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B. This is a condition of their enrollment. Enrollees must provide a copy of their Medicare card to the PEBB Program as proof of enrollment in Medicare. If an Enrollee is not entitled to either Medicare Part A or Part B on his or her 65th birthday, the Enrollee must provide the PEBB Program with a copy of the appropriate documentation from the Social Security Administration. The only exception to this rule is for employees who retired before July 1991.

4. Eligible Dependents.

To be enrolled in a medical plan a Dependent must be eligible and the Subscriber must follow the procedural requirements described in “Enrollment,” Subsection C. The PEBB Program verifies the eligibility of all Dependents and requires Subscribers provide documents that prove a Dependent’s eligibility.

- e. Lawful spouse.
- f. Registered domestic partner, defined to include the following:
 - 1) Effective January 1, 2010, a state-registered domestic partner; or
 - 2) A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before **January 1, 2010**, and was continuously enrolled under the employee in a PEBB health plan or life insurance.
- g. Children. Children are eligible up to age 26 except as described in Subsection 9 of this section. Children are defined as the Subscriber’s:
 - 1) Children as defined in state statutes that establish the parent-child relationship.
 - 2) Biological children, where parental rights have not been terminated;
 - 3) Stepchildren The stepchild’s relationship to a Subscriber (and eligibility as a PEBB Dependent) ends on the same date the Subscriber’s legal relationship with the spouse or registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
 - 4) Legally adopted children;

- 5) Children for whom the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
 - 6) Children of the Subscriber's registered domestic partner;
 - 7) Children specified in a court order or divorce decree;
 - 8) Extended Dependents in the legal custody or legal guardianship of the Subscriber, the Subscriber's spouse, or Subscriber's registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the Subscriber through the state Department of Social and Health Services foster care program; and
 - 9) Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly Dependent upon the Subscriber for support and maintenance provided such condition occurs before age 26.
 - The Subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
 - The Subscriber must notify the PEBB Program in writing when his or her Dependent is not eligible under this section. The notification must be received by the PEBB Program no later than 60 days after the date that child age 26 or older no longer qualifies under this subsection.
 - A child with a disability or physical handicap who becomes self-supporting is not eligible as of the last day of the month in which he or she becomes capable of self-support.
 - A child with a developmental disability or physician handicap age 26 and older who becomes capable of self-support does not regain eligibility if he or she later becomes incapable of self-support.
 - The PEBB Program will verify the disability and dependency of children with disabilities periodically, but no more frequently than annually after the two-year period following the child's 26th birthday.
- h. Parents.
- 1) Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
 - The parent maintains continuous enrollment in a PEBB medical plan;
 - The parent qualifies under the Internal Revenue Code as a Dependent of the Subscriber;
 - The Subscriber continues enrollment in PEBB insurance coverage; and
 - The parent is not covered by any other group medical plan.
 - 2) Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the Subscriber. Parents may not enroll additional Dependents to their insurance coverage.

B. Deferring Enrollment in PEBB Retiree Coverage.

Retiring employees and surviving Dependents (except for survivors of emergency service personnel killed in the line of duty) who want to defer enrollment must submit a Retiree coverage Election/Change form to the PEBB Program. The forms must be received by the PEBB Program no later than 60 days after the employer-paid or COBRA Coverage ends. If a retiree defers enrollment in a PEBB medical plan, they also defer enrollment for all eligible Dependents. Retiring employees and surviving Dependents that do not enroll in a PEBB medical plan are only eligible to enroll later if they have deferred enrollment as identified below:

- Beginning January 1, 2001, retirees may defer enrollment in a PEBB medical plan if they are enrolled in employer-based group medical insurance as an employee or the Dependent of an employee, or such medical insurance continued under COBRA.
- Beginning January 1, 2001, retirees may defer enrollment in a PEBB medical plan if they are enrolled in medical as a retiree or the Dependent of a retiree enrolled in a federal retiree plan.
- Beginning January 1, 2006, retirees may defer enrollment in a PEBB medical plan if they are enrolled in Medicare Parts A and B and a Medicaid program that includes payment of medical and hospital benefits.
- Beginning January 1, 2014, retirees who are not eligible for Part A and Part B of Medicare may defer enrollment in a PEBB medical plan if they are enrolled in coverage through a health care exchange developed under the Affordable Care Act.

C. Enrollment

1. How to Enroll.

Retirees and surviving Dependents must submit an *Retiree Coverage Election/Change* form to enroll in or defer enrollment in PEBB retiree insurance coverage. The form must be received no later than 60 days after the date they become eligible to enroll. Surviving Dependents of emergency service personnel killed in the line of duty must submit a Retiree Coverage Election/Change form no later than 180 days after the later of the date of the letter from the Department of retirement Systems or the Board for Volunteer Firefighters and Reserve Officers or the date of the employee's death, or the last day the surviving Dependent was covered under a health plan or COBRA through the emergency service employee's employer. If a retiree or surviving Dependent(s) cancels his or her PEBB retiree insurance coverage, he or she is not eligible to enroll at a later date unless enrollment was deferred.

To enroll a Dependent the Subscriber must include the Dependent's enrollment information and provide any required document(s) as evidence of the Dependent's eligibility. The PEBB Program will not enroll or reenroll Dependents if the PEBB Program is unable to verify a Dependent's eligibility.

- a. A Subscriber may enroll his or her Dependents during the PEBB annual open enrollment (see "Annual Open Enrollment below) or during a special open enrollment (see Special Open Enrollment below). The Subscriber must provide evidence of the event that created the special open enrollment.
- b. Subscribers are required to remove Dependents no later than 60 days from the last day of the month when the Dependent no longer meets the eligibility criteria described under "Eligible Dependents" in Section VI.A(2) of this booklet. Consequences for not submitting notice within 60 days may include, but are not limited to:
 - 1) The Dependent may lose eligibility to continue health plan coverage under one of the Options for Continuing PEBB Medical Coverage options listed in Subsection E;
 - 2) The Subscriber may be billed for claims paid by the Health plan for services that were rendered after the Dependent lost eligibility;
 - 3) The Subscriber may not be able to recover Subscriber-paid insurance premiums for Dependents that lost their eligibility; and
 - 4) The Subscriber may be responsible for premiums paid by the state for the Dependent's health plan coverage after the Dependent lost eligibility.

2. When Medical Coverage Begins.

- a. For eligible employee and their Dependents enrolling in PEBB retiree insurance coverage within 60 days of the employee's employer-paid or COBRA coverage ending, medical coverage on the first day of the month following the loss of employer-paid or COBRA coverage.
- b. For a retiree who deferred enrollment and is enrolling in PEBB retiree insurance no later than 60 days following a loss of other coverage, medical coverage will begin on the first day of the month following the loss of other coverage..
- c. For an eligible surviving Dependent, medical coverage will be continued without a gap subject to payment of premium..
- d. For a retiree's or surviving Dependent's Dependent enrolled during the PEBB annual open enrollment, medical coverage will begin on January 1 of the following year.
- e. For a retiree's or surviving Dependent's Dependent enrolled during a special open enrollment, medical coverage will be the first of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.
- f. Exceptions:

- 1) If the special open enrollment is due to the birth or adoption of a child, or when the Subscriber has assumed a legal obligation for total or partial support in anticipation or adoption of a child, medical plan coverage will begin the month in which it occurs.
- 2) If adding a child who becomes eligible as an extended Dependent through legal custody or legal guardianship, or a child who becomes eligible as a Dependent with a disability, medical coverage will begin on the first day of the month following eligibility certification.

3. Enrollment Following Deferral.

1. Retirees or surviving Dependents who defer enrollment may enroll in a PEBB medical plan during the annual open enrollment or no later than 60 days after their enrollment in employer-based group medical insurance ends as long as they were continuously enrolled in such coverage. Retirees or surviving Dependents who defer enrollment while enrolled in a federal retiree plan as a retiree or Dependent will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB annual open enrollment period or no later than 60 days after their enrollment in a medical plan under the federal retiree plan ends as long as they were continuously enrolled in a medical plan.
2. Retirees or surviving Dependents who defer enrollment while covered under a Medicaid program that provides creditable coverage may enroll in a PEBB medical plan during the PEBB annual enrollment period or no later than 60 days after their Medicaid coverage ends or no later than the end of the calendar year when their Medicaid coverage ends if they were also eligible under subsidized Medicare Part D.
3. Retirees or surviving Dependents who defer enrollment while enrolled in coverage through a health care exchange developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB annual open enrollment period or no later than 60 days after exchange coverage ends by submitting the required forms and evidence of continuous enrollment in exchange coverage to the PEBB Program. Retirees or surviving Dependents who defer enrollment may enroll in a PEBB health plan if he or she receives formal notice that the HCA has determined it is more cost-effective to enroll in a PEBB medical than a medical assistance program.
4. To enroll in a PEBB medical plan, the retiree or surviving Dependent must send a *Retiree Coverage Election/Change* form and evidence of continuous enrollment to the PEBB Program.

Retirees and surviving Dependents should contact the PEBB Program to obtain the appropriate forms, information on premiums, and available medical plans.

4. Annual Open Enrollment.

Subscribers may make a change to their enrollment during the PEBB annual open enrollment as follows:

- Enroll in or defer his or her enrollment in a medical plan;
- Enroll or remove eligible Dependents; or
- Change medical plan choice.

5. Special Open Enrollment.

- i. Subscribers may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must correspond to and be consistent with the event that creates the special open enrollment for the Subscriber or the Subscriber's Dependent.:

Exception: A retiree or surviving Dependent may cancel a Dependent's enrollment at any time. Retirees or surviving Dependents who have deferred their PEBB retiree insurance coverage may only enroll as described in the "Enrollment Following Deferral" section.

- j. To make an enrollment change, the Subscriber must submit the appropriate form(s) to the PEBB Program. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program will require the Subscriber to prove eligibility or provide evidence of the event that created the special open enrollment.

Exception: If a Subscriber wants to enroll a newborn or child whom the employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the Subscriber should notify PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 12 months after the date of birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

6. When may a Subscriber change his or her health plan? Any one of the following events may create a special open enrollment:

- a. Subscriber acquires a new Dependent due to:
 - 1) Marriage or registering a domestic partnership.
 - 2) Birth, adoption or when the employee assumes a legal obligation for total or partial support in anticipation of adoption,
 - 3) A child becomes eligible as an extended Dependent through legal custody or legal guardianship, or
 - 4) A child becomes eligible as a Dependent with a disability.
- b. Subscriber or Subscriber's Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
- c. Subscriber or Subscriber's Dependent has a change in employment status that affects the Subscriber or Subscriber's Dependent's eligibility for the employer contribution toward employer-based group health insurance;
- d. Subscriber or Subscriber's Dependent has a change in residence that affects health plan availability. If the Subscriber moves and the Subscriber's current health plan is not available in the new location the Subscriber must select a new health plan;
- e. A court order or National Medical Support Notice requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former spouse or former registered domestic partner is not an eligible Dependent);
- f. Subscriber or a Subscriber's Dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or the Subscriber's Dependent loses eligibility for coverage under Medicaid or CHIP;
- g. Subscriber or Subscriber's Dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a CHIP;
- h. Subscriber or Subscriber's Dependent becomes entitled to coverage under Medicare, or the Subscriber or a Subscriber's Dependent loses eligibility for coverage under Medicare, or enrolls in or cancels enrollment in a Medicare Part D plan. If the Subscriber's current health plan becomes unavailable due to the Subscriber or Subscriber's Dependent's entitlement to Medicare, the Subscriber must select a new health plan;
- i. Subscriber or Subscriber's Dependent's current health plan becomes unavailable because the Subscriber or enrolled Dependent is no longer eligible for a health savings account (HSA);
- j. Subscriber or Subscriber's Dependent experiences a disruption of care that could function as a reduction in benefits for the Subscriber or Subscriber's Dependent for a specific condition or ongoing course of treatment. The Subscriber may not change his or her health plan election if the Subscriber or Dependent's physician stops participation with the Subscriber's health plan unless the PEBB Program

determines that continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:

- 1) Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
- 2) Transplant within the last 12 months; or
- 3) Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for this continuity of care); or
- 4) Recent major surgery still within the postoperative period ; or
- 5) Third trimester of pregnancy.

7. When may a Subscriber enroll or remove eligible Dependents? Any one of the following events may create a special open enrollment:

- a. Subscriber acquires a new Dependent due to:
 - 1) Marriage or registering a domestic partnership,
 - 2) Birth adoption or when a Subscriber has assumed a legal obligation for total or partial support in anticipation or adoption,
 - 3) A child becoming eligible as an extended Dependent through legal custody or legal guardianship; or
 - 4) A child becoming eligible as a Dependent with a disability.
- b. Subscriber or Subscriber's Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
- c. Subscriber or Subscriber's Dependent has a change in employment status that affects the Subscriber or Subscriber's Dependent's eligibility for their employer contribution toward employer-based group health insurance;
- d. Subscriber or Subscriber's Dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
- e. Subscriber's Dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
- f. A court order or National Medical Support Notice requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent (a former spouse or former registered domestic partner is not an eligible Dependent);
- g. Subscriber or Subscriber's Dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or Subscriber's Dependent loses eligibility for coverage under Medicaid or a CHIP.
- h. Subscriber or Subscriber's Dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

D. Medicare Entitlement.

1. Medicare Part A and Medicare Part B

If an Enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration office to ask about Medicare enrollment. Unless retirement occurred before July 1, 1991, or the Enrollee is a Dependent of an employee who retired before July 1, 1991 and is enrolled in PEBB coverage, the Enrollee must enroll and maintain enrollment in a Medicare Part A and Medicare part B. Medicare will become the primary insurance coverage, in most cases, and the PEBB retiree medical plan will become the secondary insurance coverage.

2. Medicare Part D

PEBB has determined that the PEBB Classic Retiree Plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is “creditable coverage”). Therefore, you cannot enroll in Medicare Part D and remain on the PEBB Classic Retiree Plan. If you choose to enroll in Medicare Part D, you may continue your PEBB coverage only by enrolling in PEBB-sponsored Medicare supplement plan.

E. When Medical Coverage Ends.

1. Medical Plan enrollment ends on the following dates:

- 1) On the last day of the month when any individual ceases to be eligible.
- 2) On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.
- 3) For an Enrollee who declines the opportunity or is ineligible to continue enrollment under one of the options described in the “Options for continuing PEBB Medical Coverage” in Subsection F, coverage ends for the Enrollee on the last day of the month in which he or she ceases to be eligible.
- 4) If the Subscriber stops paying monthly premiums, coverage ends for the Subscriber and enrolled Dependents on the last day of the month for which the last full premium was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an Enrollee dies or a Subscriber requests to cancel his or her medical coverage before the end of the month.

2. The Enrollee is responsible for timely payment of premiums and reporting changes in eligibility or address.

- The Enrollee and his or her covered dependent(s) or beneficiary is responsible for reporting changes no later than 60 days after the event, such as divorce, termination of a registered domestic partnership, death, or when a Dependent no longer meets the eligibility criteria described under “Eligible Dependents.”
- Failure to report changes can result in loss of premiums and loss of the Subscriber and his or her Dependent’s right to continue coverage under one of the continuation of coverage options described in the “Options for Continuing PEBB Medical Coverage.” To obtain forms, Subscribers can contact PEBB Customer Service at 1-800-200-1004.
- If an Enrollee or newborn eligible for benefits under “Maternity” is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the Enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:
 - (a.) The Enrollee is discharged from the hospital or from a hospital to which the Enrollee is directly transferred.
 - (b.) The Enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization.
 - (c.) The Enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the Enrollee is directly transferred.
 - (d.) The Enrollee is covered by another health plan that will provide benefits for the services.
 - (e.) Benefits are exhausted.

When medical plan enrollment ends, the Enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the time limits explained in the following sections.

F. Options for Continuing PEBB Medical Coverage.

Subscribers and their Dependents covered by this medical plan may be eligible to continue enrollment if they lose eligibility and are eligible under one of the following options for continuing coverage: COBRA

1. COBRA gives Enrollees the right to continue group coverage for 18 to 36 months. Refer to the Continuation of Coverage Election Notice booklet for specific details.
2. PEBB Extension of Coverage allows for continued retiree coverage of Dependents of a deceased Subscriber.
3. PEBB retiree insurance coverage

The first two options above temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your Dependent's PEBB medical coverage. COBRA coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative for PEBB Enrollees who are not eligible for COBRA.

The third option above is only available to surviving Dependents who meet eligibility requirements. Contact PEBB Customer Service at 1-800-200-1004 or refer to the Continuation of Coverage Election Notice booklet for details.

G. Conversion of Coverage.

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by this plan when they are no longer able to continue the PEBB coverage, and are not eligible for Medicare or another group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group coverage ends or within 31 days from the date notice of the termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. The rates, coverage and eligibility requirements of our conversion plan differ from those of the Enrollee's current group plan. Enrollment in a conversion plan may limit the Enrollee's ability to later purchase an individual plan without health screening or a preexisting condition waiting period. To obtain detailed information on conversion options under this plan, call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

H. Appeals of Determinations of PEBB Eligibility.

Any Enrollee may appeal a decision made by the PEBB Program regarding eligibility, enrollment, or premium payments to the PEBB appeals committee.

Any Enrollee may appeal a decision regarding administration of a PEBB medical plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment determinations.

I. Relationship to Law and Regulations.

Any provision of this Certificate of Coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

J. Customer Service

If you have questions about your PEBB retiree eligibility and benefit information, please contact the PEBB Program at 1-800-200-1004 or go to www.hca.wa.gov/pebb. For questions about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or go to www.medicare.gov.

VII. Grievances

Grievance means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. The grievance process is outlined as follows:

Step 1: The Enrollee should contact the person involved, explain his/her concerns and what he/she would like to have done to resolve the problem. The Enrollee should be specific and make his/her position clear.

Step 2: If the Enrollee is not satisfied, or if he/she prefers not to talk with the person involved, the Enrollee should call the department head or the manager of the medical center or department where he/she is having a problem. That person will investigate the Enrollee's concerns. Most concerns can be resolved in this way.

Step 3: If the Enrollee is still not satisfied, he/she should call Customer Service at 206-901-4636 or toll-free 1-888-901-4636. Most concerns are handled by phone within a few days. In some cases the Enrollee will be

asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. A Customer Service Representative will investigate the Enrollee's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Enrollee Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Enrollee's written statement.

If the Enrollee is dissatisfied with the resolution of the complaint, he/she may contact Customer Service. Assistance is available to Enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

VIII. Appeals

Enrollees are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the Group Health medical director. The appeals process is available for an Enrollee to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Enrollee's eligibility to participate in a plan. Group Health will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting Group Health's Member Appeal Department at the address or telephone number below.

1. Initial Appeal

If the Enrollee or the Enrollee's legal representative wishes to appeal a Group Health decision to deny, modify, reduce or terminate coverage of or payment for health care services, he/she must submit a request for an appeal either orally or in writing to Group Health's Member Appeal Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Group Health will notify the Enrollee of its receipt of the request within 72 hours of receiving it. Appeals should be directed to Group Health's Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, toll-free 1-866-458-5479.

A party not involved in the initial coverage determination and not a subordinate of the party making the initial coverage determination will review the appeal request. Group Health will then notify the Enrollee of its determination or need for an extension of time within 14 days of receiving the request for appeal. Under no circumstances will the review timeframe exceed 30 days without the Enrollee's written permission.

For appeals involving experimental or investigational services Group Health will make a decision and communicate the decision to the Enrollee in writing within 20 working days of receipt of the appeal.

There is an **expedited/urgent appeals process** in place for cases which meet criteria or where delay using the standard appeal review process will seriously jeopardize the Enrollee's life, health or ability to regain maximum function or subject the Enrollee to severe pain that cannot be managed adequately without the requested care or treatment. The Enrollee can request an expedited/urgent appeal in writing to the above address, or by calling Group Health's Member Appeal Department toll-free 1-866-458-5479. The nature of the patient's condition will be evaluated by a physician and if the request is not accepted as urgent, the Enrollee will be notified in writing of the decision not to expedite and given a description on how to grieve the decision. If the request is made by the treating physician who believes the Enrollee's condition meets the definition of expedited, the request will be processed as expedited.

The request for an expedited/urgent appeal will be processed and a decision issued no later than 72 hours after receipt of the request.

The Enrollee may also request an external review at the same time as the internal appeals process if it is an urgent care situation or the Enrollee is in an ongoing course of treatment.

If the Enrollee requests an appeal of a Group Health decision denying benefits for care currently being received, Group Health will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the Group Health determination stands, the Enrollee may be responsible for the cost of coverage received during the review period.

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or at toll-free 1-800-562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at <http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/>.

2. Next Level of Appeal

If the Enrollee is not satisfied with the decision regarding medical necessity, medical appropriateness, health care setting, level of care, or if the requested service is not efficacious or otherwise unjustified under evidence-based medical criteria, or if Group Health fails to adhere to the requirements of the appeals process, the Enrollee may request a second level review by an external independent review organization not legally affiliated with or controlled by Group Health. Group Health will notify the Enrollee of the name of the external independent review organization and its contact information. The external independent review organization will accept additional written information for up to five business days after it receives the assignment for the appeal. The external independent review will be conducted at no cost to the Enrollee. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through Group Health.

A request for a review by an independent review organization must be made within 180 days after the date of the initial appeal decision notice.

IX. Claims

Claims for benefits may be made before or after services are obtained. Group Health recommends that the provider requests Preauthorization. In most instances, contracted providers submit claims directly to Group Health. If your provider does not submit a claim to make a claim for benefits, a Enrollee must contact Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If an Enrollee receives a bill for services the Enrollee believes are covered, the Enrollee must, within 90 days of the date of service, or as soon thereafter as reasonably possible, either (1) contact Customer Service to make a claim or (2) pay the bill and submit a claim for reimbursement of Covered Services to Group Health, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than 1 year from the date of service.

Group Health will generally process claims for benefits within the following timeframes after Group Health receives the claims:

- Pre-service claims – within 15 days.
- Claims involving urgently needed care – within 72 hours.
- Concurrent care claims – within 24 hours.
- Post-service claims – within 30 days.

Timeframes for pre-service and post-service claims can be extended by Group Health for up to an additional 15 days. Enrollee will be notified in writing of such extension prior to the expiration of the initial timeframe.

X. Coordination of Benefits

The coordination of benefits (COB) provision applies when a Enrollee has health care coverage under more than one plan. Benefits will not be coordinated with any individual health care plan that covers the Enrollee. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

If the Enrollee is covered by more than one health benefit plan, and the Enrollee does not know which is the primary plan, the Enrollee or the Enrollee's provider should contact any one of the health plans to verify which plan is primary. The health plan the Enrollee contacts is responsible for working with the other plan to determine which is primary and will let the Enrollee know within 30 calendar days.

All health plans have timely claim filing requirements. If the Enrollee or the Enrollee's provider fails to submit the Enrollee's claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If the Enrollee experiences delays in the processing of the claim by the primary health plan, the Enrollee or the Enrollee's provider will need to submit the claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

If the Enrollee is covered by more than one health benefit plan, the Enrollee or the Enrollee's provider should file all the Enrollee's claims with each plan at the same time. If Medicare is the Enrollee's primary plan, Medicare may submit the Enrollee's claims to the Enrollee's secondary carrier.

Definitions.

- A. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Enrollees of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.
 - 1. Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

Each contract for coverage under Subsection 1. or 2. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Enrollee has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered Enrollee. This reserve must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period.

- D. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Enrollee is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
 2. If an Enrollee is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
 3. If an Enrollee is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 4. An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.
- E. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of Emergency or referral by a panel member.
 - F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules.

When an Enrollee is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- B. (1) Except as provided below (subsection 2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- D. Each plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The plan that covers the Enrollee other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Enrollee as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Enrollee as a Dependent, and primary to the plan covering the Enrollee as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Enrollee as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.
 2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
 - ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
 - iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subsection a) above determine the order of benefits; or
 - v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent, first;
 - The plan covering the spouse of the custodial parent, second;
 - The plan covering the non-custodial parent, third; and then

- The plan covering the spouse of the non-custodial parent, last.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subsection a) or b) above determine the order of benefits as if those individuals were the parents of the child.
 3. Active employee or retired or laid-off employee. The plan that covers a Enrollee as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Enrollee as a retired or laid off employee is the secondary plan. The same would hold true if a Enrollee is a Dependent of an active employee and that same Enrollee is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Section D(1) can determine the order of benefits.
 4. COBRA or State Continuation Coverage. If a Enrollee whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Enrollee as an employee, member, Subscriber or retiree or covering the Enrollee as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Section D.1. can determine the order of benefits.
 5. Longer or shorter length of coverage. The plan that covered the Enrollee as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Enrollee the shorter period of time is the secondary plan.
 6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan.

When this plan is secondary, it must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Enrollee be responsible for a deductible amount greater than the highest of the two deductibles.

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Group Health may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Enrollee claiming benefits. Group Health need not tell, or get the consent of, any Enrollee to do this. Each Enrollee claiming benefits under this plan must give Group Health any facts it needs to apply those rules and determine benefits payable.

Facility of Payment.

If payments that should have been made under this plan are made by another plan, Group Health has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, Group Health is fully discharged from liability under this plan.

Right of Recovery.

Group Health has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. Group Health may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits? Contact the State Insurance Department.

Effect of Medicare.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by Group Health as set forth in this section. Group Health will pay primary to Medicare when required by federal law. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

When a Network Provider renders care to a Enrollee who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, Group Health will seek Medicare reimbursement for all Medicare covered services.

XI. Subrogation and Reimbursement Rights

The benefits under this Benefits Booklet will be available to a Enrollee for injury or illness caused by another party, subject to the exclusions and limitations of this Benefits Booklet. If Group Health provides benefits under this Benefits Booklet for the treatment of the injury or illness, Group Health will be subrogated to any rights that the Enrollee may have to recover compensation or damages related to the injury or illness and the Enrollee shall reimburse Group Health for all benefits provided, from any amounts the Enrollee received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. This section more fully describes Group Health's subrogation and reimbursement rights.

"Injured Person" under this section means an Enrollee covered by the Benefits Booklet who sustains an injury or illness and any spouse, dependent or other person or entity that may recover on behalf of such Enrollee including the estate of the Enrollee and, if the Enrollee is a minor, the guardian or parent of the Enrollee. When referred to in this section, "Group Health's Medical Expenses" means the expenses incurred and the value of the benefits provided by Group Health under this Benefits Booklet for the care or treatment of the injury or illness sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, Group Health shall have the right to recover Group Health's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." Group Health shall be subrogated to and may enforce all rights of the Injured Person to the full extent of Group Health's Medical Expenses.

Group Health's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, Group Health's Medical Expenses are secondary, not primary.

The Injured Person and his/her agents shall cooperate fully with Group Health in its efforts to collect Group Health's Medical Expenses. This cooperation includes, but is not limited to, supplying Group Health with information about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim and informing Group Health of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit Group Health, at Group Health's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow Group Health to initiate its own direct action for reimbursement or subrogation.

The Injured Person and his/her agents shall do nothing to prejudice Group Health's subrogation and reimbursement rights. The Injured Person shall promptly notify Group Health of any tentative settlement with a third party and shall

not settle a claim without protecting Group Health's interest. If the Injured Person fails to cooperate fully with Group Health in recovery of Group Health's Medical Expenses, the Injured Person shall be responsible for directly reimbursing Group Health for 100% of Group Health's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until Group Health's subrogation and reimbursement rights are fully determined and that Group Health has an equitable lien over such monies to the full extent of Group Health's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of Group Health's Medical Expenses.

If this Benefits Booklet is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of Group Health, under special circumstances, the Injured Person may request and Group Health may agree to reduce the amount of reimbursement to Group Health by an amount for reasonable and necessary attorney's fees and costs incurred by the Injured Person on behalf of and for the benefit of Group Health, but only if such amount is agreed to in writing by Group Health prior to settlement or recovery.

To the extent the provisions of this Subrogation and Reimbursement section are deemed governed by ERISA, implementation of this section shall be deemed a part of claims administration and Group Health shall therefore have discretion to interpret its terms.

XII. Definitions

Allowance	The maximum amount payable by Group Health for certain Covered Services.
Allowed Amount	A term used to define the level of benefits which are payable by Group Health when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Enrollees shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount.
Benefits Booklet	The Benefits Booklet is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between Group Health and the Group.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount an Enrollee is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Enrollee is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which an Enrollee is entitled to coverage in the Benefits Booklet.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under Group Health's prescription drug coverage is at

	least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount an Enrollee is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Enrollee's health, or if the Enrollee is pregnant, the health of her unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Enrollee	Any enrolled Subscriber or Dependent.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Family Unit	A Subscriber and all his/her Dependents.
Group	An employer, union, welfare trust or bona-fide association which has entered into a Group medical coverage agreement with Group Health.
Group Health-designated Specialist	A specialist specifically identified by Group Health.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Enrollees will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by Group Health's medical director according to generally accepted principles of good medical practice, which are rendered to an Enrollee for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Enrollee, his/her family or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Enrollee; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under Group Health's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with

	accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Enrollee's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Enrollee's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by Group Health's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Network Facility	A facility (hospital, medical center or health care center) owned, operated or otherwise designated by Group Health, or with whom Group Health has contracted to provide health care services to Enrollees.
Network Personal Physician	A provider who is employed by or contracted with Group Health to provide primary care services to Enrollees and is selected by each Enrollee to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Benefits Booklet which a Enrollee can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Enrollee.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by Group Health, and any other health care professional or provider with whom Group Health has contracted to provide health care services to Enrollees, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.
Out-of-pocket Expenses	Those Cost Shares paid by the Subscriber or Enrollee for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and his/her Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV.
Plan Coinsurance	The percentage amount the Enrollee is required to pay for Covered Services received.
Preauthorization	An approval by Group Health that entitles an Enrollee to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the Benefits Booklet. Enrollees who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center.

	Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah.
Subscriber	A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled and for whom the premium has been paid.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.